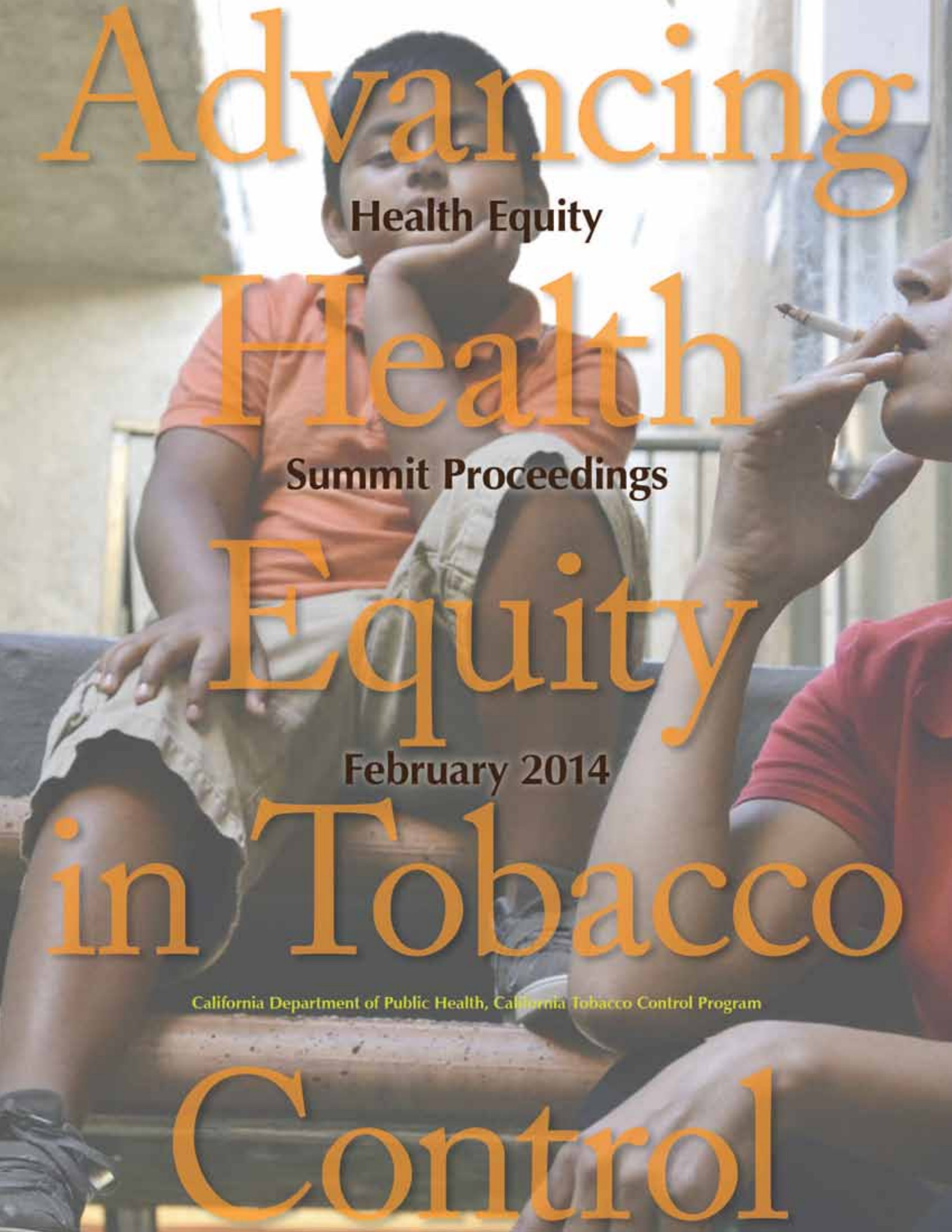

Advancing Health Equity in Tobacco Control

Summit Proceedings

February 2014

California Department of Public Health, California Tobacco Control Program

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Health Equity Summit
June 25-26, 2013
Sacramento, California

Summit Proceedings

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Foreword

Tobacco prevention and control efforts give the rest of us hope. Hope that we can turn the health of our state and our country around for the better. Tobacco prevention efforts of the last twenty-five years have demonstrated what is possible with comprehensive changes in policy and practices and have shown the public—and public health—the power of policy, organizational practice, and norms change in improving health outcomes and morbidity rates for all. Tobacco prevention efforts provide an instructive road map for taking on significant chronic disease challenges.

First, tobacco prevention and control efforts have led the chronic disease prevention field—refocusing attention from a sole focus on individual behaviors like smoking to a broader focus on the environmental and social factors that influence disparate tobacco usage and disproportionate rates of illness and mortality.

Secondly, because of the successes, new knowledge, and perhaps even occasional missteps that have accumulated through collective efforts to reduce tobacco consumption, today's tobacco prevention and control practitioners provide a basis and a set of partners for addressing the community conditions that impact a range of health behaviors and outcomes. In the same communities where tobacco use, marketing, and sales are highest, issues related to a lack of access to healthy food and, the proliferation of unhealthy products—highly processed food, alcohol and tobacco, for instance—are fueling an epidemic of inter-related chronic diseases; preventable chronic disease.

Finally, there is a strong evidence base that suggests that root factors such as economic structures, lack of access to jobs, unhealthy housing conditions, discrimination, and oppression underlie common causes of illness, injury and disease; whether they are tobacco-related, food-related, inactivity-related illnesses, or violence-related. This suggests that if we can begin to unearth and undo broad social ills like poverty and racism, we can make a positive difference in a host of health conditions simultaneously. In this view, the people who carry out tobacco control and prevention efforts are essential partners and allies in guiding us to a future where the toll of chronic disease is lower for everyone and where it will no longer be possible to predict a person's life expectancy based on their zip code.

Much work remains to be done to eliminate tobacco use and prevent tobacco-related illness, especially among groups disproportionately impacted by tobacco use. This report specifically focuses on efforts and directions for California Tobacco Control Program (CTCP) and its partners. It suggests some of the key opportunities for leveraging tobacco prevention efforts to improve community conditions and to address broader social determinants; however, it is recognized that the recommendations provide a starting point only. This report is not intended as an exhaustive blueprint for action.

Prevention Institute was honored to work with CTCP staff and its partners to hone in on opportunities for advancing health equity in the context of current CTCP strategy, and hopes this report serves to advance and accelerate this important work in California.

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CTCP also expresses its gratitude to all the Summit participants and presenters, many of whom traveled great distances to share their expertise and participate in discussions. Their insights provided the substance of this report. The **presenters and participants** are listed and acknowledged in Appendix B.

Lastly, the **Summit facilitators**, Dalila Butler, Larry Cohen, and Shayla Spilker of Prevention Institute deserve a special thank you for their outstanding contributions to the facilitation and success of the Summit.

Executive Summary

California's tobacco prevention and control efforts of the last twenty-five years have demonstrated the power of policy, organizational practice, and norms change in improving health outcomes and morbidity rates for all. However, despite this success, large differences in smoking prevalence persist for adults and youth by race/ethnicity and among population groups by socioeconomic status, educational attainment, occupation, mental health status, sexual orientation, and geography. As tobacco prevention and control continues to build momentum for promoting healthful community conditions and saving lives, there has been an emphasis on more holistic approaches that apply a health equity lens to ensure all environments support tobacco-free living and health. This means a focus on the social determinants of health and the community factors that address the structural drivers that impact inequities, such as racism and poverty.

***Advancing Equity: THRIVE* Health Clusters and Community Factors that Influence Health:**

Equitable Opportunity

- Education
- Living Wages & Local Wealth

Place

- What's sold & how it's promoted
- Look, feel, & safety
- Parks & open space
- Getting around/Transportation
- Housing
- Air, water, soil
- Arts & cultural expression

People

- Social networks & trust
- Participation & willingness to act for the common good
- Norms & culture

Health Care

- Preventive services
- Access
- Treatment quality, disease management, in-patient services, & alternative medicine
- Cultural competence
- Emergency response

In order to create a vision and direction for reducing tobacco-related health disparities and addressing factors that impact health equity in California, the California Department of Public Health (CDPH), California Tobacco Control Program (CTCP) hosted a Health Equity Summit in June, 2013. During the Health Equity Summit, participants explored a range of strategies to improve community conditions and opportunities to examine tobacco prevention efforts with a health equity lens—considering opportunities for building community capacity and leadership as well as identifying potential barriers and unintended consequences that need to be addressed upfront.

Opportunities to apply a health equity lens include:

- Endorsing a paradigm shift in how to look at equity. For example, supporting and building communities' ability to engage in reducing inequities at the state/local level; identifying creative ways to eliminate inequities; and measuring equity differently (e.g., city report cards).
- Listening and responding to community needs and maintaining accountability for addressing the needs that are expressed.

- Supporting inclusive decision-making structures to ensure that populations impacted by inequities have input and influence and see tangible results of their influence.
- Investing in capacity and infrastructure in priority populations.
- Building local and state health department capacity to include and support leadership from under-resourced or over-burdened communities.
- Using opportunities within population-wide strategies to embed diverse leaders and to concentrate resources in the communities that need them most.
- Supplementing population-based approaches with targeted interventions for communities experiencing inequities.
- Working with "unusual partners" or organizations that may not have been engaged in this work before (e.g. retail associations, Chambers of Commerce, construction builders associations).
- Linking to long-term activities. Focusing on smaller efforts that are not comprehensive or integrated into sustainable activities may not be fruitful in the long run.
- Using tobacco prevention successes to support and accelerate progress by bridging partnerships and fostering diverse equity oriented coalitions and networks.

Top 11 Priority Strategies from the CTCP Health Equity Summit*:

1. Adopt & enforce smoke-free policies in alternative settings (e.g., hospitals, behavioral health, prisons)
2. Fund priority populations advocacy & leadership alliances
3. Investment in community and capacity building
4. Minimum price on tobacco products & tobacco tax
5. Flavored product sales ban
6. Tobacco-free colleges (e.g., community, tech, and trade)
7. Convene health equity oversight committee
8. Commercial tobacco-free workplaces (outdoors) (e.g., construction sites)
9. Environmental design framework inclusive of tobacco-free considerations
10. Sustained comprehensive media campaign to promote cessation benefits to providers, medical patients, and behavioral health
11. Healthy/clean housing policies that integrate smoke-free multi-unit housing

* These strategies are not intended to be listed in order of importance.

Recommendations & Next Steps

- **It takes all of us**. CTCP will play a large role in ensuring the strategies and foundational skills highlighted throughout the report are planned and implemented with an explicit equity focus. In addition, multi-sectoral partnerships with groups (those previously engaged in tobacco-prevention efforts as well as the "unusual" suspects) will be key to maximizing the impact of these efforts.

  Example action: Fund additional priority population advocacy and leadership alliances at conservative levels of funding.

- **Cross-cutting efforts can help to achieve the greatest impact for reducing tobacco-related disparities**. By developing approaches and solutions that address multiple problems and provide win-win outcomes across different sectors, California's tobacco prevention and control efforts can accelerate health equity. In addition to addressing multiple issues, cross-cutting efforts can help build relationships and connections that support successful partnerships longer-term.

  Example actions: Support a retail strategy banning flavored tobacco sales and promoting the sale of healthful products; partner with advocates to implement healthy/clean housing policies that integrate smoke-free multi-unit housing; and work with partners to implement tobacco-free campuses and workplaces (outdoors).

- Building skills and providing training to CTCP staff, as well as with partners and the community, is integral to maintaining the momentum towards advancing equity. Health equity is not a simple concept that lends itself to a one-time training. To build staff and community capacity around health equity, it is important to establish a strong system of training and skill-building at all levels.

  Example action: Invest in community and capacity building strategies such as trainings for staff and partner organizations as well as leadership institutes for community residents.

"Tobacco and Its Impact in My Community" Photo Contest
Photo by Jocelyn Gutierrez, Platinum Winner - Secondhand Smoke, November 2013

Introduction: Moving Toward Health Equity

Over the last 25 years, the California Department of Public Health (CDPH), California Tobacco Control Program (CTCP) has reduced tobacco use, the initiation of tobacco use, and protected non-smokers from secondhand smoke. As a result, CTCP has helped advance the broader work of community prevention across California. Working alongside local, state and federal partners, CTCP has had great success in reducing the adult smoking prevalence of Californians from 23.7 percent in 1988 to 12.7 percent in 2012, a nearly 50 percent decline.[1] Despite this success, large differences in smoking prevalence persist for adults and youth by race/ethnicity and among population groups by socioeconomic status, educational attainment, occupation, mental health status, sexual orientation, and geography. These high risk groups suffer disproportionately from tobacco-related illness and death despite the progress made in reducing adult tobacco use in California.

"**Tobacco-related disparities** are differences in patterns, prevention, and treatment of tobacco use; differences in the risk, incidence, morbidity, mortality, and burden of tobacco-related illness that exist among specific population groups in the United States; and related differences in capacity and infrastructure, access to resources and environmental tobacco smoke exposure."[2]

Health equity means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.[3]

To address California communities' tobacco-related disparities at a time when the breadth of diversity of the state and the nation is expanding, CTCP has placed a growing emphasis on the role that tobacco-prevention efforts can play in advancing health equity for our state's most under-resourced populations. In order to create a vision and direction for reducing tobacco-related health disparities and addressing factors that impact health equity in California, CTCP hosted a Health Equity Summit in June, 2013. Prevention Institute, a national non-profit organization dedicated to advancing community health and equity worked with CTCP to shape and facilitate the Summit.

The Health Equity Summit provided a forum for discussing the inequities underlying unfair and unhealthy differences in tobacco exposure, use, and outcomes. During the Health Equity Summit, participants shared information, expertise, and vetted population-based strategies and approaches to reduce tobacco-related disparities. While the Health Equity Summit was structured to look at tobacco-specific strategies, participants also pointed to opportunities to address tobacco use in partnership with other sectors to address shared neighborhood concerns, like oversaturation of unhealthy products, as well as through further exploration of the social determinants of health and how they impact rates of tobacco use.

THRIVE Community Prevention Framework at the Health Equity Summit

THRIVE (Tool for Health and Resilience in Vulnerable Environments) is a research-based framework that describes the relationship between underlying social conditions, community-level factors and various health behaviors and exposures that, in turn, result in differential outcomes. *THRIVE* was used as a guiding framework for development of the Health Equity Summit agenda, and small group activities and discussion. The *THRIVE* framework was used to facilitate a common vocabulary and foster a shared understanding of the relationship between public health efforts and community change initiatives as participants explored a range of strategies to improve community conditions and modify structural drivers of inequities.

THRIVE illustrates the inter-relatedness between 17 community factors and their influence on health and safety. It demonstrates how the relative presence or absence of these healthy community factors is associated with social inequities, such as racism, classism, bias, oppression, and power.

Tobacco-related disparities typically follow a pattern aligned with other health disparities, such as differences in diabetes rates or asthma. The presence of polluters, lack of access to fresh foods, or proliferation and persistent marketing of tobacco products frequently coincide, causing certain communities to bear the burden of risk factors and unhealthy exposures. The clustering of risks is not random or accidental. There are a host of historical and current policies, organizational practices, and other strategies that shape community conditions.

Some building blocks of healthy communities include an effective educational system, fair and affordable health and social services, safe parks and community gathering places, clean air, and the marketing and availability of healthy products (such as healthy food) as opposed to unhealthy products (such as tobacco). Research confirms the relationship between such factors and health and safety outcomes. For instance, tobacco price and point-of-sale strategies to reduce tobacco marketing can positively impact health. Studies have demonstrated that increasing the unit price of tobacco products is associated with reduced prevalence of tobacco use, reduced tobacco-related morbidity and mortality, and reduced tobacco-related disparities among income groups. These are potent and effective strategies to address tobacco consumption; similar strategies could be equally effective with other unhealthy products.

Addressing health equity is a significant challenge of vital urgency and there are numerous strategies—including changing policies and organizational practices—that public health can engage in with partners to produce health benefits and fortify the structures, policies, and processes that produce fair and equitable health outcomes. (See *Appendix A* for the full description of *THRIVE*.)

Advancing Equity: THRIVE Health Clusters and Factors*:

Equitable Opportunity

- Education
- Living Wages & Local Wealth

Place

- What's sold & how it's promoted
- Look, feel, & safety
- Parks & open space
- Getting around/Transportation
- Housing
- Air, water, soil
- Arts & cultural expression

People

- Social networks & trust
- Participation & willingness to act for the common good
- Norms & culture

Health Care

- Preventive services
- Access
- Treatment quality, disease management, in-patient services, and alternative medicine
- Cultural competence
- Emergency response

*This is not an exhaustive list of factors. The health and safety of communities can also be impacted by factors such as weathering (the early health deterioration as a consequence of the cumulative impact of repeated experience with social, economic, or political marginalization)[4], cumulative disadvantage (the process whereby individuals carry forward those disadvantages of early life through sequential life stages, often resulting in later life poverty or poor health)[5], and the stress of dealing with discrimination.

Photo by TEAM Lab

Overview of the Health Equity Summit

Purpose of the Summit

The purpose of the Health Equity Summit was three-fold:

1. To create a strategic vision for California's tobacco control and other chronic disease efforts to achieve tobacco-related health equity;
2. To strengthen partnerships and encourage interagency collaboration in order to support an integrated approach to addressing tobacco-related health inequities in the state; and
3. To identify a set of achievable, population-specific outcome measures.

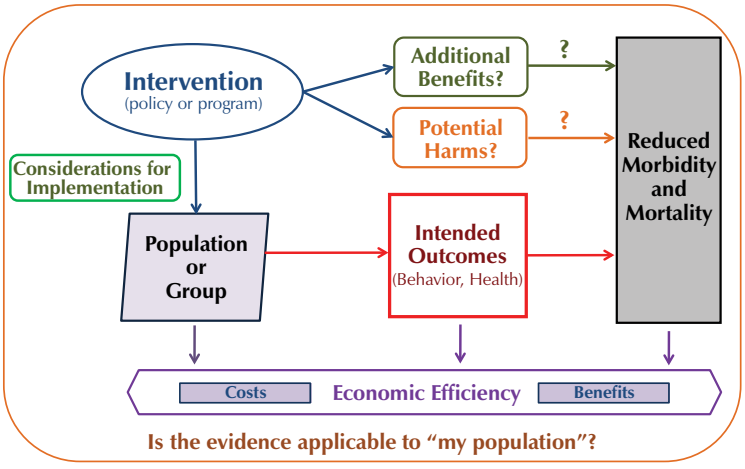
More than 50 tobacco control partners and other stakeholders (see *Appendix B* for full list) attended and contributed to the development of the tobacco health equity strategy elements. Over the course of the Summit, participants were broken into small working groups, which were intentionally selected to include a multi-sectoral mix of local, state, and national representation (see *Appendix C* for Health Equity Summit Agenda).

Setting the Stage

While tobacco control and prevention efforts have been highly successful in reducing the overall prevalence of tobacco use and exposure across the U.S., there is still work to be done, particularly related to creating equitable health outcomes and ensuring that all population groups benefit to the greatest extent possible from new and existing policies and programs. Thus, many national and state agencies have begun to review and assess their strategies and recommendations to determine which evidence-based strategies and policies successfully reduce tobacco use and exposure while also reducing disparities among at-risk populations. In order to provide context for participants, national data on intervention effectiveness was embedded into the first day of the Summit.

The Centers for Disease Control and Prevention (CDC) is one federal agency focused on updating the research and recommendations behind tobacco use prevention and control policies and programs to promote more equitable health outcomes. CDC's Community Guide[6] conducts systematic research reviews focused on population-based interventions, considering benefits or unintended harms, economic costs, and contribution to reducing disparities (Figure 1).

Figure 1. Issues Considered in Community Guide Reviews



Of the strategies and policies reviewed in the Community Guide, tobacco control policies, such as comprehensive smoke-free policies, tobacco product price increases, programs such as mobile phone and quitline cessation programs, and mass-reach health communication interventions, are demonstrated to be effective and are recommended.

Why do tobacco inequities persist?*

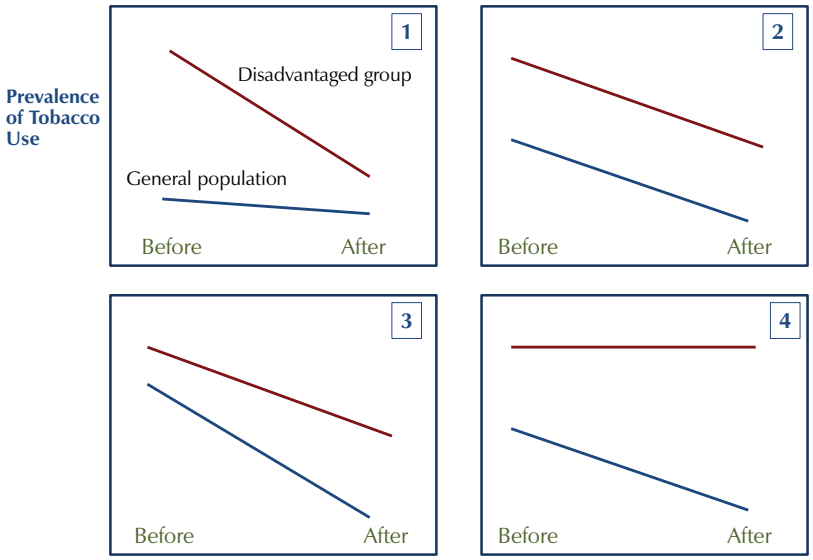
- Tobacco industry targeting
- Predatory marketing to vulnerable populations
- Adolescent vulnerability and exposure
- Feelings of hopelessness or stress
- Cumulative disadvantage
- Systemic targeting of disadvantaged neighborhoods
- Discrimination and 'isms', both external and internalized
- Disparities in health care quality

* This is not an exhaustive list.

In addition to having sufficient evidence that a policy or practice works to reduce tobacco consumption and exposure, the Community Guide Task Force also strives to determine how an intervention can be targeted to specific populations in order to address disparities and avoid widening the tobacco use prevalence gap between the general population and disadvantaged groups. Figure 2, example 1 shows the desired effect of an intervention that is effectively addressing disparities (i.e., the prevalence gap is decreasing). Examples 2 through 4 in Figure 2 show how an intervention that does not explicitly consider population-level differences can create persistent health disparities (i.e., the prevalence gap either remains the same as prevalence declines, or the gap widens between groups). Strategies for addressing the prevalence gap include considering how to improve socioeconomic factors or changing physical environments to make healthy options the default, as well as strategically thinking through the implications associated with certain intervention characteristics such as fairness, scale, and targetability.[7]

While updating policy recommendations is one important aspect of further expanding tobacco control policies and programs, looking closely at the factors in the social-cultural and physical environment that influence health outcomes and searching further "upstream" for underlying causes of differences in tobacco exposure and use are also necessary to reduce tobacco-related disparities. The list of **Why do tobacco inequities persist** identifies some of the reasons why these tobacco-related disparities endure; these factors were also presented at the beginning of the Summit to provide context for participants.

Figure 2. Gaps in Intervention Effectiveness



Environmental factors, such as the targeted and predatory marketing of tobacco products to certain population groups, or disparate access to quality health care services that promote cessation, impact the consumption of and exposure to tobacco products and make it more difficult for individuals to quit. With that in mind, Summit participants were encouraged to think broadly about how to address some of the environmental factors that further exacerbate tobacco inequities by considering new ways to partner with different groups, determining how to integrate tobacco control and empowerment initiatives, and promoting robust community engagement in tobacco control efforts.

Where Are We Now? Tobacco Use and Smoke Exposure in California

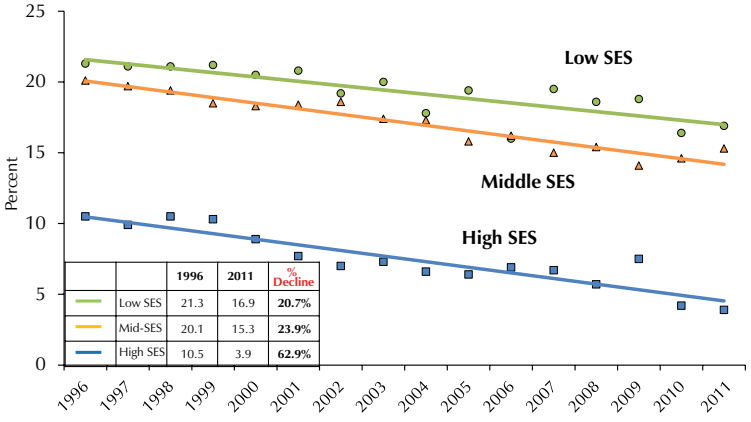
Despite overall declines in adult and youth smoking prevalence in California over the past 25 years, certain population groups continue to smoke or use tobacco products at elevated rates, including American Indians/Alaska Natives, African Americans, Native Hawaiians/Pacific Islanders, Hispanics, men, lesbian/gay/bisexual/transgender individuals, some youth populations, people with lower levels of education, and individuals with low socioeconomic status (SES).[8, 9]

Looking at smoking prevalence by differences in SES highlights the gaps in tobacco control intervention effectiveness and/or reach. For example, although there has been a visible decline in smoking prevalence across all socioeconomic groups since 1996, the extreme difference in percent decline between High SES groups (62.9%) and Low SES groups (20.7%) points to the need for interventions that more effectively reduce smoking rates for groups suffering disproportionately from tobacco use (Figure 3).

Similarly, when looking at smoking prevalence among California men, women, or high school youth by race/ethnicity, the differences in

Figure 3: Smoking Prevalence among Adults by SES

Smoking prevalence among California adults by SES, 1996-2011

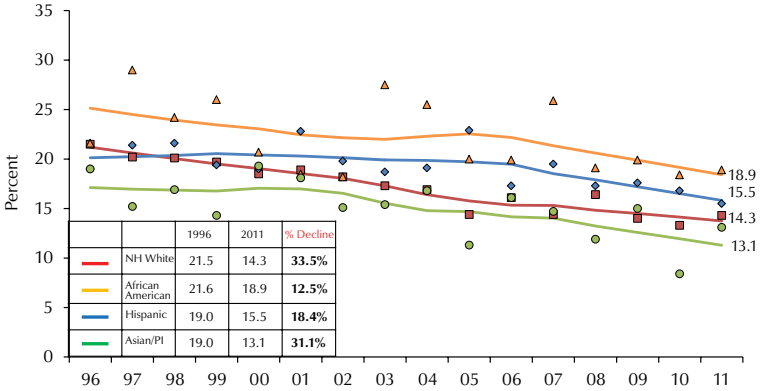


	1996	2011	% Decline
Low SES	21.3	16.9	**20.7%**
Mid-SES	20.1	15.3	**23.9%**
High SES	10.5	3.9	**62.9%**

Source: Behavioral Risk Factor Surveillance System. The data is weighted to the 2000 California population.
Note change of smoking definition in 1996 that included more occasional smokers.
Prepared by: California Department of Public Health, California Tobacco Control Program

Figure 4: Smoking Prevalence among California Men

Smoking prevalence among California men by race/ethnicity, 1996-2011

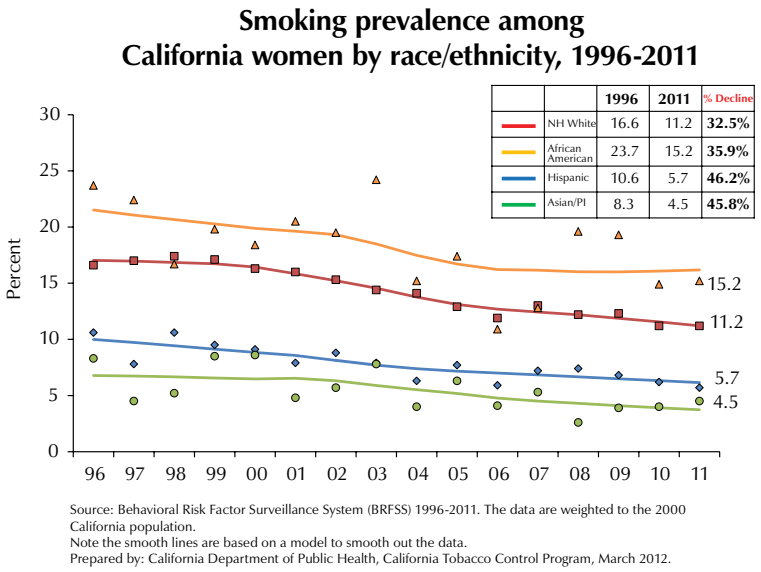


	1996	2011	% Decline
NH White	21.5	14.3	**33.5%**
African American	21.6	18.9	**12.5%**
Hispanic	19.0	15.5	**18.4%**
Asian/PI	19.0	13.1	**31.1%**

Source: Behavioral Risk Factor Surveillance System (BRFSS) 1996-2011. The data are weighted to the 2000 California population.
Note the smooth lines are based on a model to smooth out the data.
Prepared by: California Department of Public Health, California Tobacco Control Program, March 2012.

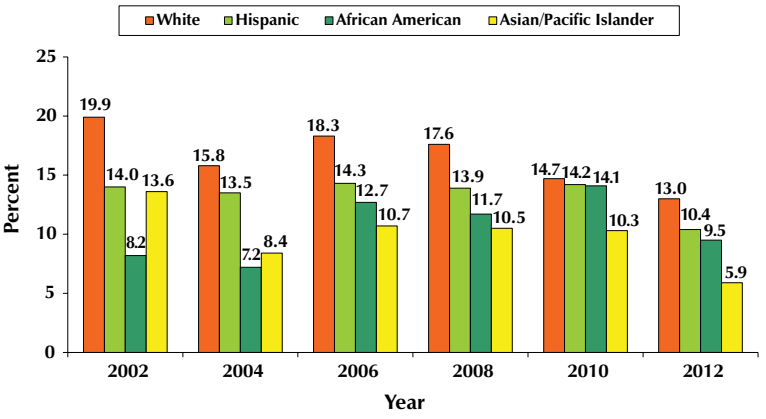
intervention effectiveness and/or reach become apparent. Since 1996, overall rates of smoking have declined for all adult groups. However, the percent decline between population sub-groups, such as non-Hispanic white men (33.5% decline) and African American men (12.5% decline), is striking (Figure 4). Among women, the percent declines are relatively high across all groups; however, disparities persist when you consider the absolute smoking rates in some groups such as African American women (Figure 5). In the case of high school youth, while White students have seen an overall decline in smoking prevalence since 2002, other racial/ethnic groups have seen variable prevalence rates, with African American students in particular smoking more in 2012 than they did in 2002 (Figure 6).

Figure 5: Smoking Prevalence among California Women



Source: Behavioral Risk Factor Surveillance System (BRFSS) 1996-2011. The data are weighted to the 2000 California population.
Note the smooth lines are based on a model to smooth out the data.
Prepared by: California Department of Public Health, California Tobacco Control Program, March 2012.

Figure 6: 30- Day Smoking Prevalence of High School Students



Source: The 2000 California data is from the National Youth Tobacco Survey (NYTS) collected by the American Legacy Foundation, which used passive parental consent. The other year data are from the California Student Tobacco Survey.
Prepared by: California Department of Public Health, California Tobacco Control Program.

Despite considerable progress in reducing smoking rates among all groups, it is evident that all groups have not benefited equally from tobacco control efforts in California and that troubling disparities persist. Many of these persistent disparities are likely rooted in inequitable community conditions such as increased availability and exposure to tobacco products. During the Health Equity Summit, participants sought to understand how the root causes of health inequity shape community conditions and how conditions in the community environment impact smoking prevalence.

Racially and economically segregated communities are more likely to have limited economic opportunities and lower performing schools, lack healthy options for food and physical activity, experience higher rates of crime and incarceration, and higher costs for common goods and

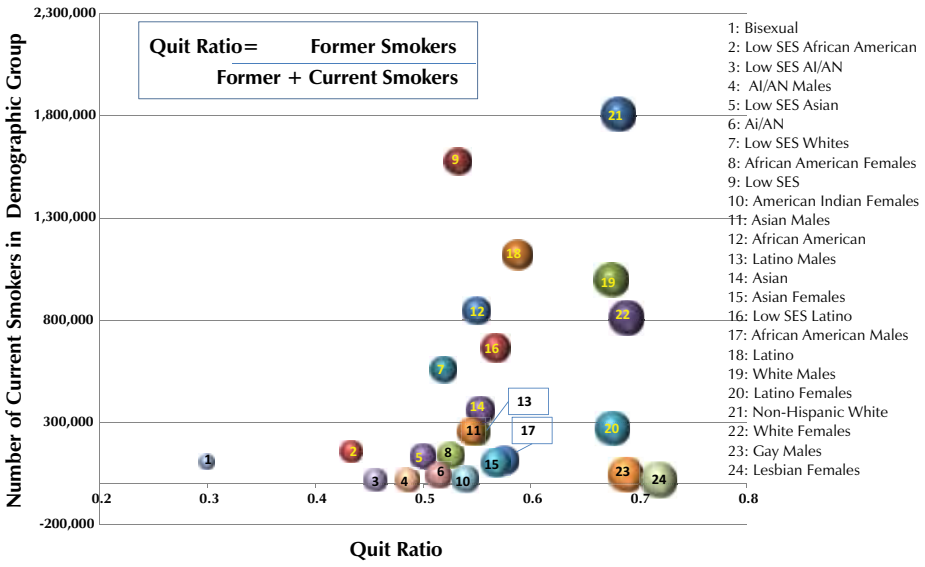
services (the so-called "poverty tax").[10] These differences in the community environment build on one another and create different experiences and norms in different communities. Further, they impact a host of exposures and behaviors, including tobacco use and exposure, which in turn impact health outcomes. Tobacco retailers, for example, are more frequently located in low-income communities and communities of color,[11, 12] which results in easier access to tobacco products and increased opportunity for culturally tailored and targeted marketing to specific populations such as African Americans and youth (Figure 7).[13, 14]

Figure 7: NYC Department of Health and Mental Hygiene

Secondhand smoke exposure is another area where differences in the community environment impact health. Low-income residents and residents of color who live in multi-unit housing can be particularly vulnerable to secondhand smoke if no protective smoke-free policy is in place.[15, 14] In the workplace, if exemptions to smoke-free policies exist, or no policy is in place at all, then blue-collar and service sector workers – many of whom are people of color, immigrants, young people and individuals with limited education and low income – are prone to experience disproportionate secondhand smoke exposure.[17, 18]

There are also disparities across groups in terms of successful quitting behaviors. Non-Hispanic whites, Latino females, Lesbian females and Gay males have relatively high quit ratios, meaning that of the total population of former and current smokers combined, more individuals are former smokers than current. For low SES American Indian/Alaska Native and African American populations, however, the quit ratio is much lower (Figure 8).

Figure 8: Quit Ratio Among Various Smoker Demographic Groups



Source: California Health Interview Survey, 2009. Data restricted to adults aged 18 years and older. Low SES is defined as ≤200 Federal Poverty Limit.
Prepared by: California Department of Public Health, California Tobacco Control Program, May 2013.

Access to culturally appropriate cessation information and resources can also impact how equitable a tobacco control strategy may be. In communities where many residents are under- or uninsured and have limited access to health care providers, successful quit attempts may be low. Integrating cessation supports into new or existing policies is one strategy to mitigate differential quit rates.

Overwhelmingly, California's data show that individuals with higher SES, White and well-educated, are the most likely to successfully quit smoking (Figure 8). (See *Appendix D* for a description of and link to additional California tobacco-specific data charts that were presented during an interactive Gallery Walk at the Summit.)

In order for California to continue leading the way in tobacco control and prevention efforts, particularly with an increasingly diverse population, multi-level efforts that bridge diverse sectors will need to focus on policies and strategies that address the community conditions which push back on the structural drivers of health inequity.

Health Equity Summit Approach

Day 1: Identify and Select Priority Strategies to Address Tobacco-Related Health Inequities

Health Equity Summit participants were asked to identify and select priority strategies that would have the greatest impact on reducing tobacco use disparities and accelerating the rate of decline among population groups with high rates of tobacco use.

Policy, Systems & Environmental Change: Definitions and Examples [19]

Type of change	Definition	Examples
Policy	Interventions that create or amend laws, ordinances, resolutions, mandates, regulations, or rules	Increasing taxes on cigarettes to discourage purchase and use of tobacco
Systems	Interventions that impact all elements of an organization institution or system	Shifting funding practices to prioritize funding advocacy & leadership alliances for populations impacted by tobacco-related inequities
Environmental	Interventions that involve physical or material changes to the economic, social, or physical environment	Implementing tobacco-free school zones

Using Prevention Institute's THRIVE framework as a guide, participants broke into small work groups based on eight overarching topic areas emphasizing policy, systems, and environmental change. The desired product for each small group on day one was a list of three to five policy or system change strategies. Participants were broken up into the following groups (full definitions for each of these groups can be found in Appendix E):

- Healthcare
- People & Equitable Opportunity
- Place: What's sold & how it's promoted: Retail Environment
- Place: What's sold & how it's promoted: Non-retail Environment

- Place: Look, feel, & safety; Getting around/transportation
- Place: Housing
- Place: Air, water & soil
- Place: Parks & open space

In preparation for the Health Equity Summit, a number of baseline criteria were chosen for consideration. The pre-determined criteria included:

- Quality—Supported by evidence-base and community wisdom
- Reach—Size of the population that would likely be effected
- Cost—Estimated cost to implement and evaluate
- Actionability—Legal and political feasibility
- Priority Populations Impacted—Which priority population groups would be most impacted if the strategy were to be implemented

Health Equity Summit participants generated additional criteria to guide their strategy selection and prioritization. Strategies were to:

- Influence equity
- Have massive impact
- Be doable
- Involve meaningful community engagement
- Build capacity and infrastructure in priority populations
- Facilitate multi-sectoral efforts
- Balance evidence base and community wisdom
- Address underlying/root causes

After the small groups brainstormed lists of top strategies by theme, they reported back to the large group. The large group prioritized the top eleven policy and system change strategies that would have the greatest impact on reducing tobacco use disparities in California.

Day 2: Identify and Select Operational Strategies to Address Tobacco-Related Health Inequities

Operational or Foundational Strategies are cross-cutting functions that guide public health practice. These strategies determine the elements of *how* the work gets done. Operational and foundational strategies include approaches such as collecting and evaluating data, developing partnerships, and engaging impacted communities.

Recognizing the profound influence of income inequality, racism, oppression, and bias underlying health inequities, Health Equity Summit attendees were tasked with thinking about tobacco use inequities in a broad frame, while also considering operational and foundational strategies that influence tobacco use. This includes: ensuring that health equity is considered in all elements of the work including across operational approaches; fostering multi-sector partner-

ships with new and diverse partners; meaningfully engaging community to advance tobacco control interventions; collecting and using data to accurately identify where health inequities exist; respecting and responding to cultural differences; and evaluating efforts comprehensively to understand if they are impacting inequities.

Following the day one small group work, Summit attendees transitioned into different small group configurations on day two to discuss the operational and foundational strategies necessary to advance equity. The Summit focused on the following operational approaches:

- Media/Public Relations Strategies
- Capacity Building Strategies: Tools/Training/Technical Assistance Services
- Community Engagement Strategies
- Development of Collaborative Partnerships
- Data Measurement & Evaluation

After small group brainstorming was complete, each group briefly reported back to the large group and participated in a facilitated discussion regarding major themes and next steps. All information and notes from the full Summit were collected to provide a summation of the findings.

Key Takeaways & Results of the Health Equity Summit

One purpose of the Health Equity Summit was to develop a comprehensive strategy to address tobacco-related disparities by focusing in on the health equity considerations for tobacco-related strategies as well as for overarching foundational approaches. While the Health Equity Summit was structured to look at tobacco-specific strategies, interest from participants also pointed to opportunities to address tobacco-related inequities through cross-cutting efforts in alignment with other sectors as well as through further exploration of the Social Determinants of Health and how they impact rates of tobacco use. There were a number of key takeaways that surfaced during conversation among participants, most notably, the opportunities to further strengthen efforts by applying a health equity lens to the work.

Opportunities to apply a health equity lens include:

- Endorsing a paradigm shift in how to look at equity. For example, supporting and building communities' ability to engage in reducing inequities at the state/local level; identifying creative ways to eliminate inequities; and measuring equity differently (e.g., city report cards).
- Listening and responding to community needs and maintaining accountability for addressing the needs that are expressed.
- Supporting inclusive decision-making structures to ensure that populations impacted by inequities have input and influence and see tangible results of their influence.
- Investing in capacity and infrastructure in priority populations.
- Building local and state health department capacity to include and support leadership from under-resourced or over-burdened communities.
- Using opportunities within population-wide strategies to embed diverse leaders and to concentrate resources in the communities that need them most.
- Supplementing population-based approaches with targeted interventions for communities experiencing inequities.
- Working with the "unusual partners" or organizations that may not have been engaged in this work before (e.g., retail associations, Chambers of Commerce, construction builders associations).
- Linking to long-term activities. Focusing on smaller efforts that are not comprehensive or integrated into sustainable activities may not be fruitful in the long run.
- Using tobacco prevention successes to support and accelerate progress and partnerships in other fundamental areas of health, like housing, healthy food retail, and economic development, by bridging partnerships and fostering diverse equity oriented coalitions and networks.

Strategy Selection

The Saving Our Legacy, African Americans for Smoke-Free Safe Places (SOL) Project worked with the Sacramento Regional Transit District (SRTD) and community youth to adopt a 100% smoke-free policy near all bus stops and light rail stations. SOL Project staff, recognizing the impact of tobacco use and exposure on youth, engaged community youth serving on the Youth Advisory Board to help make the case for the importance of smoke-free policies in the community. The SOL Project's youth volunteers, called the "SOLdiers", held cigarette litter pick-up events to demonstrate the need for a smoke-free policy. They collected over 5,600 pieces of tobacco litter at 75 bus stops and light rail stations in only four hours' time. The research and information developed with the help of the youth volunteers set the stage for policy action and played an important role in affecting change. SRTD's new policy will protect thousands of passengers from secondhand smoke and reduce the number of cigarette butts and paraphernalia that litter transit stations across Sacramento.

To hone in on the most impactful strategies, Health Equity Summit participants were asked to focus on population-based policy, systems, and environmental change strategies that would reduce tobacco use disparities and accelerate declines in use.

Top 11 Priority Strategies from the CTCP Health Equity Summit*:

1. Adopt & enforce smoke-free policies in alternative settings (e.g., hospitals, behavioral health, prisons)
2. Fund priority populations advocacy & leadership alliances
3. Invest in community and capacity building
4. Establish minimum price on tobacco products & increase the tobacco tax
5. Eliminate flavored tobacco product sales
6. Establish tobacco-free colleges (e.g., community, tech, and trade)
7. Convene a health equity oversight committee**
8. Establish commercial tobacco-free workplaces (outdoors) (e.g., construction sites)
9. Environmental design framework inclusive of tobacco-free considerations
10. Sustain a comprehensive media campaign to promote cessation benefits to providers, medical patients, and behavioral health
11. Establish healthy/clean housing policies that integrate smoke-free multi-unit housing

* These strategies are not intended to be listed in order of importance.

** Health and Safety Code Sections 13100-131225 (Statutes, 2012, Chapter 23, Section 43) legislatively established the Office of Health Equity within the California Department of Public Health (CDPH) and established a state-wide Health Equity Oversight Committee. Therefore, this recommended strategy will need to be addressed in concert with the CDPH Office of Health Equity and the enabling legislation to avoid duplication.

Merging Tobacco-Specific Strategies and Foundational Approaches to Achieve Health Equity

The California LGBT Tobacco Education Partnership (the Partnership) aimed to decrease the widespread availability of tobacco products in pharmacies. The Partnership focused on San Francisco's Castro District, where smoking rates within the LGBT population are high. The Partnership engaged pharmacies that were already tobacco-free and educated community stakeholders on the benefits of tobacco-free pharmacies to build support. To ensure that every San Franciscan had access to tobacco-free pharmacies, the Partnership also worked to implement a citywide strategy by making a compelling, research-supported argument that pharmacies should be hubs for health—not dispensaries for tobacco. As a result, San Francisco became the first U.S. city to eliminate the sale of tobacco products in its pharmacies in 2008.

The 11 strategies serve as the basis for prioritizing and guiding the strategic direction of CTCP's efforts to address health equity. The strategies are critical to the continued success of tobacco prevention and control efforts in California. However, these specific strategies alone cannot advance health equity. How the work is done matters. Successful efforts to achieve health equity improve community conditions in a way that pushes back against structural drivers of inequities.

In order to address tobacco-related disparities in California, efforts will need to focus on developing a shared understanding and comprehensive approach by engaging communities, fostering leadership and strengthening advocate and community capacity to change community environments to support health. In addition, working with partners from other sectors (e.g., healthy eating and active living advocates, planning departments) could strengthen the approaches, reduce costs of planning and implementation, and build stronger community will.

The work of CTCP and its partners should explicitly apply a health equity lens to the key foundational approaches such as data measurement and evaluation and meaningful engagement and leadership development within impacted communities. Doing this work requires a constant negotiation and recalibration, as each decision has the potential to advance health equity or contribute to widening the gap in health outcomes.

While smoke-free multi-unit housing policies are becoming the norm in urban areas, many rural counties and towns are still working toward implementing better protections from secondhand smoke for all residents in and near their homes. For example, Petaluma is working toward more equitable smoke-free indoor policies. An initial policy proposed for the city would have exempted certain areas, including a percentage of rooms in hotels and motels, and certain shared public spaces. The Petaluma City Council decided to strengthen the policy by revising the ordinance to improve protections for all individuals. The new policy protects everyone living in multi-family housing, including condominiums, by banning smoking indoors as well as outdoors in shared common space, and protects employees by creating a 100% smoke-free environment in hotels and motels.

Applying Foundational Approaches across Tobacco-Specific Strategies to Achieve Equity

Understanding how foundational approaches link to and strengthen the 11 priority strategies identified at the Health Equity Summit will move CTCP closer to achieving health equity and reducing tobacco-related disparities.

Recommended Strategies to Strengthen Media and Public Relations

- Use media to educate populations about policies before they are implemented to generate buy-in (e.g., smoke-free multi-unit housing, smoke-free workplaces, and healthcare).
- Strengthen the use of media across communities experiencing inequities by providing resources to ethnic-specific media, including training, grants and capacity building.
- Go beyond traditional media outlets and consider progressive and independent media (e.g., social media); create messages that come from communities and counter the use of images that glorify tobacco use among different groups; partnership with community and other organizations is vital.

"Population-based approaches need to be supplemented by targeted interventions by communities in need."
--Jonathan Isler, California Tobacco Control Program

Recommended Strategies to Build Capacity

- Provide comprehensive training around how to advance health equity for tobacco advocates and practitioners as well as partners, communities, youth peer leaders, and indigenous trainers in priority populations.
- Create small grant opportunities ($10-15K grants) for local organizations to assess communities, identify problems and create buy-in for solutions.
- Develop leadership trainings with partners and community members to ensure that partners and communities are linked in at the local level.

Santa Clara County's Tobacco Prevention program partnered with established community-based organizations (CBOs) to expand access to cessation services to all residents. Many CBOs were already poised to implement cessation services in neighborhoods with high numbers of smokers. The Santa Clara County Public Health Department (SCPHD) awarded mini-grants to CBOs to expand cessation services, with most grants supporting organizations working with Vietnamese, African American, Latino, and Lesbian, Gay, Bisexual, and Transgender communities. SCPHD also engaged diverse partners ranging from churches to the Viet-American Voters group. As a result of the partnership efforts, cessation services are now available to some of the most vulnerable populations in the county and have resulted in an overall 39% quit success rate.

Recommended Strategies to Engage Community

- Create systemic practices that ensure community buy-in and adequate long-term investment in communities. For example, include community input and influence in decision-making, implementation, and co-creation of strategies and metrics.
- Identify best practices: understand where the community is at, meet people where they are, identify ambassadors and intercommunity champions, in particularly youth.

Recommended Strategies to Improve Development of Collaborative Partnerships

- Involve existing networks working with priority populations and tap into them to more systematically pursue a dialogue about addressing health inequities (e.g., youth leadership groups).
- Work with other sectors engaged in reducing inequities in community determinants and pushing back against structural drivers of inequities.
- Use asset mapping to identify and extend outreach to other groups and 'unusual suspects' (e.g., faith community, construction builders associations).
- Create a strong case that highlights the win-win outcome when advocating for adopting/implementing a policy or restricting product/use, especially when it impacts communities experiencing inequities.

> **"[We have to realize that] small efforts here and there that aren't comprehensive won't be fruitful in the long run. It involves a broader set of partnerships and longer length of time…because we're talking about changing the entire system."**
>
> *--Lourdes Baezconde-Garbanati, Tobacco Education and Materials Lab*

Recommended Strategies for Improving Data Measurement and Evaluation

- Focus on accelerating the decline in tobacco use among priority populations while remembering that a decline across all groups is desired.
- Review all data collection instruments and how they connect to different interventions; oversample different priority populations in surveys like the Behavioral Risk Factor Surveillance System (BRFSS) to engage communities with information relevant to them and consider working with impacted communities to co-create measurements; look at regional estimates and drill down further to get specific at a more local level.

Photo by TEAM Lab

Recommendations & Next Steps

The Health Equity Summit served as an important milestone for CTCP and its partners across California by creating a vision for reducing tobacco-related health disparities and identifying tangible actions to address these disparities. The discussion among participants served as a key jumping off point for further dialogue, deeper reflection, and greater collaboration across efforts to achieve health equity. Some key recommendations include the following:

- **It takes all of us.** CTCP will play a large role in ensuring the strategies and foundational skills highlighted throughout the report are planned and implemented with an explicit equity focus. In addition, multi-sectoral partnerships with groups (those previously engaged in tobacco-prevention efforts as well as the "unusual" suspects) will be key to maximizing the impact of these efforts. There are a number of potential partners that could be engaged in advancing health equity by reducing tobacco-related disparities, including but not limited to: local public health departments, community groups, workers' unions, planning departments, housing associations, faith-based institutions, and others engaged in related community prevention efforts.

  Potential strategies for further building equity-focused efforts and strengthening new and existing partnerships include releasing funding opportunities that specifically require health equity experience or conducting trainings prior to the release of new funding opportunities that require an equity lens to encourage nontraditional partners to apply. Collaborating with community-based organizations already serving the populations experiencing health inequities and proactively engaging, funding, and supporting agencies new to tobacco control work are also important considerations for broadening the tobacco control movement in California.

In South Los Angeles, four convenience stores have undergone a community-driven conversion process through the Community Market Conversion Program. The Program creates healthy hubs for residents with limited access to healthy food by introducing fresh produce for sale and limiting access to unhealthy products by creating tobacco guidelines, which include steps such as moving cigarillos and other non-cigarette products away from counters and posting signs to promote smoking cessation. Community participation was key to the project with residents selecting the stores and providing outreach and education in the neighborhoods surrounding them.

Prevention Institute's *Collaboration Multiplier Tool* may help lay the groundwork for multifield collaboration by facilitating the process of identifying shared strategies, data sources, and other integral elements of partnership. (See *Appendix F* for a description of the *Collaboration Multiplier Tool*.)

Example action: Fund priority population advocacy & leadership alliances at conservative levels of funding.

- **Cross-cutting efforts can help to achieve the greatest impact for reducing tobacco-related disparities.** By developing approaches and solutions that address multiple problems and provide win-win outcomes across different sectors, California's tobacco prevention and control efforts can accelerate health equity. For example, at first consideration, preventing violence may not seem like an area of focus for tobacco prevention. However, young men and boys of color have noted that, due to community violence, they are not concerned about the long-term efforts of tobacco use, because they are dealing with other more immediate threats to their health and safety. This may be a reason for higher initiation rates of tobacco use among youth of color. Tobacco prevention practitioners and advocates can help to raise awareness of violence as a public health issue and can design tobacco prevention efforts as opportunities for meaningful youth engagement. Building hope and the capacity of youth to make community change is associated with reducing violence impacting youth.

  There are opportunities to develop cross-cutting efforts even through smaller-scale activities. For instance, healthy food advocates working with retailers to increase healthy food options and add signage announcing new healthy options available might help to reduce tobacco advertisements, especially in low-income neighborhoods where these advertisements are abundant.

  In addition to addressing multiple issues, cross-cutting efforts can help to build relationships and connections that support successful partnerships longer-term.

  Example actions: Support a retail strategy banning flavored tobacco sales and promoting the sale of healthful products; partner with advocates to implement healthy/clean housing policies that integrate smoke-free multi-unit housing; and work with partners to implement tobacco-free campuses and outdoor workplaces (e.g., construction sites).

- **Building skills and providing training to CTCP staff as well as with partners and the community is integral to maintaining the momentum towards advancing equity**. Health equity is not a simple concept that lends itself to a one-time training. To build staff and community capacity around health equity, it is important to establish a strong system of training and skill-building at all levels. Potential topics for health equity trainings could include: core concepts and definitions related to health equity; structural roots of inequity; social determinants of health; impact of policies and environments on vulnerable populations; community engagement strategies; undoing racism/bias; and communication strategies to reach diverse populations.

The National Association of County and City Health Officials' (NACCHO) Health Equity and Social Justice initiatives helps to advance the capacity of health departments to tackle the root causes of health inequities through public health practice and organizational structure. NACCHO's Roots of Health Inequity web-based course and Health Equity Campaign have been developed to help build capacity among public health practitioners.

Example action: Invest in community and capacity building strategies such as trainings for staff and partner organizations as well as leadership institutes for community residents.

"Tobacco and Its Impact in My Community" Photo Contest
Photo by Gabrielle Miller, November 2013

Appendices

"Tobacco and Its Impact in My Community" Photo Contest
Photo by Sherri Suniga, November 2013

Appendix A: Description of THRIVE

THRIVE: Tool for Health & Resilience in Vulnerable Environments

THRIVE (Tool for Health and Resilience in Vulnerable Environments) is both a process for engaging community members and practitioners in changing community conditions for better health outcomes and also a tool for assessing the status of community conditions and prioritizing them for action to improve health, safety and health equity.

THRIVE helps to develop a shared understanding among key participants of the structural drivers of inequity and how these manifest themselves at the community level to impact health, safety, and health equity. THRIVE links the ways that poverty, racism, and other forms of oppression play out at a community level to action. Providing a framework for identifying and addressing community conditions that can improve health outcomes and promote health equity, THRIVE translates research into a framework that people can understand and into a tool that enables people to identify specific factors and concrete actions that will make a difference in their communities.

THRIVE Health Clusters and Factors:

Equitable Opportunity

- Education
- Living Wages & Local Wealth

Place

- What's sold & how it's promoted
- Look, feel, & safety
- Parks & open space
- Getting around/ Transportation
- Housing
- Air, water, soil
- Arts & cultural expression

People

- Social networks & trust
- Participation & willingness to act for the common good
- Norms & culture

THRIVE is funded by a cooperative agreement from the U.S. Office of Minority Health to the National Network of Public Health Institutes and Prevention Institute. THRIVE has been piloted in rural, suburban, and urban sites. The pilot events confirmed that THRIVE contributes to a broad vision about community health; confirms the value of upstream approaches; challenges traditional thinking about health promotion; organizes difficult concepts and enables systematic planning; has rural, suburban and urban applicability; has utility for practitioners and community members; and is a good tool for strategic planning at community and organizational levels.

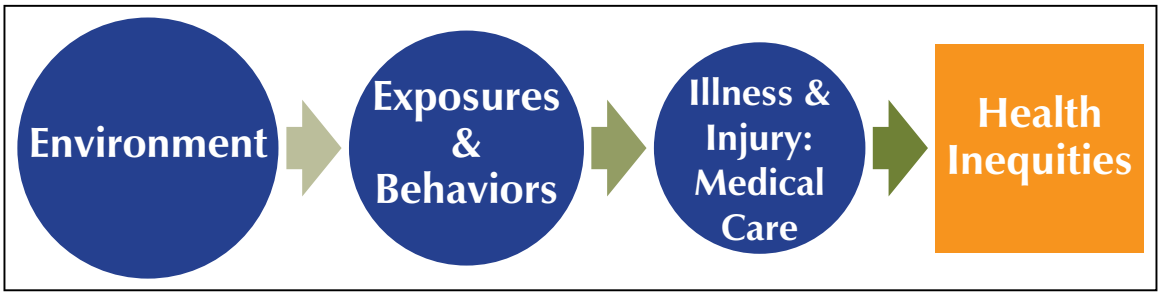
A typical THRIVE process involves convening key community members and helping build their shared understanding of both the connection of health outcomes (i.e., type II diabetes), behaviors (i.e., consumption of unhealthy foods, or limited physical activity), and community level environmental factors (i.e., grocery stores, safe accessible parks and open space). Once the shared understanding of these connections is clear, the THRIVE assessment asks participants to prioritize, at the environmental level, those factors they feel most contribute to local health inequity. Sample strategies, collected from across the U.S., are provided to help catalyze local action to address health equity.

THRIVE has a five part process:

1. **Engagement**: determining and engaging the support of key participants and decision makers, including members of the community
2. **Fostering a shared understanding**: building understanding of the determinants of health and fostering buy-in into addressing them as an effective approach to improving health and safety outcomes
3. **Assessment**: using the tool to identify the needs and assets of the community or neighborhood and the particular health concerns and inequities
4. **Planning and action**: clarifying vision, goal, and directives, establishing decision making processes and criteria, fostering sustainability, and ensuring that resources are being appropriately used. And implementing multifaceted activities to achieve desired outcomes
5. **Measuring progress**: ensuring that resources are being used in the most effective and efficient manner and that efforts are achieving the desired outcomes

THRIVE is a framework to understand how structural drivers play out at the community level to impact community conditions, and consequently, health, safety and health equity. It also helps us to understand how community change can push back against the structural drivers. The overarching goal of THRIVE is to promote health and safety and reduce health inequities. THRIVE is an opportunity to identify effective investments that are prioritized by and resonate with community members.

Health Inequities Trajectory



THRIVE is designed for local initiatives led by community health workers, community development corporations, community-based service providers, community organizers, health clinics, hospitals, public health professionals, and other health equity advocates interested in sustainable community-driven efforts to advance health equity.

You can find out more about THRIVE at www.preventioninstitute.org/THRIVE or contact us at Prevention Institute prevent@preventioninstitute.org or (510) 444-7738.

THRIVE, a collaborative project between Prevention Institute and the National Network of Public Health Institutes, is funded through a cooperative agreement with the Dept. of Health and Human Services' Office of Minority Health.

Appendix B:

List of Health Equity Summit Participants

*Denotes Summit Speakers
**Denotes External Workgroup Members

Christopher Anderson, Program Director, California Smokers' Helpline, University of California, San Diego

****Lourdes Baezconde-Garbanati**, Project Director, Tobacco Education and Materials Lab

Eric Batch, Vice President of Advocacy, American Heart Association

***Reverend Jesse W. Brown**, **Jr**., Save Lives: Ban Menthol Cigarettes Campaign

****Tiffany Chin**, Program Director, Bay Area Community Resources: Project RIDE

JamieLou Delavan, Cultural Liaison/Health Equity Program Specialist, Idaho Health & Welfare

Narinder Dhaliwal, Director, California's Clean Air Project/ETR Associates

Martha Dominguez, Program Consultant, California Department of Public Health, Maternal, Child & Adolescent Health

Leslie Ferreira, Program Consultant, California Department of Public Health, Tobacco Control Program

George Flores, Program Manager, The California Endowment

Julissa Gomez, Advocacy Manager, The Center for Tobacco Policy & Organizing

Bob Gordon, Project Director, California LGBT Tobacco Education Partnership

Joseph Guydish, Professor, Institute for Health Policy Studies, University of California, San Francisco

Laura Hamasaka, Associate Vice President, Legacy Foundation

***Lisa Henriksen**, Senior Research Scientist, Stanford Prevention Research Center

Evi Hernandez, Director of Program Services, California Health Collaborative

Sally Herndon, North Carolina Department of Health and Human Services, Tobacco Prevention and Control Branch

Norval Hickman, Program Officer for Social Behavioral Sciences, Tobacco-Related Disease Research Program

Kimberlee Homer Vagadori, Project Director, California Youth Advocacy Network

***David Hopkins**, Medical Epidemiologist, Centers for Disease Control and Prevention

Jonathan Isler, Chief, California Department of Public Health, Tobacco Control Program

Jim Knox, Vice President, Legislative Advocacy of the American Cancer Society

Richard Kwong, Sr. Policy Strategist, California Department of Public Health, Tobacco Control Program

Rod Lew, Executive Director, Asian Pacific Partners for Empowerment Advocacy and Leadership

Luci Longoria, Health Promotion Manager, Oregon Public Health Division

Kristi Maryman, Program Consultant, California Department of Public Health, Tobacco Control Program

Amanda McCartney, Media Specialist, California Department of Public Health, Tobacco Control Program

Carol McGruder, Co-Chair, African American Tobacco Control Leadership Council

Francisco Michel, Media Specialist, California Department of Public Health, Tobacco Control Program

****Daniele Minock**, Project Coordinator, Siskiyou Department of Public Health

Mary Modayil, Research Scientist, California Department of Public Health, Tobacco Control Program

Claud Moradian, Los Angeles County Department of Public Health, Policy Unit

Chad Morris, Associate Professor, University of Colorado Denver, Department of Psychiatry

***Patricia Nez Henderson**, Vice President, Black Hills Center for American Indian Health

****Jessica Núñez de Ybarra**, Public Health Medical Officer III, California Department of Public Health, Coordinated Chronic Disease Prevention

Sang-Mi Oh, Vice President Health Equity, American Heart Association/American Stroke Association

Rosanna Oliva, Marketing Manager, California Department of Public Health's Network for a Healthy California

Anne Pearson, Vice President of Programs, ChangeLab Solutions

Thea Perrino, Program Consultant, California Department of Public Health, Tobacco Control Program

Myron Dean Quon, Esq., Executive Director, National Asian Pacific American Families Against Substance Abuse

Zoila Reyna, Program Consultant, California Department of Public Health, Tobacco Control Program

April Roeseler, Chief, California Department of Public Health, Tobacco Control Program

***Linda Rudolph**, Principal Investigator for Health in All Policies, Public Health Institute

Shirley Shelton, Program Consultant, California Department of Public Health, Tobacco Control Program

Mandeep Sohi, Procurement Manager, California Department of Public Health, Tobacco Control Program

****Claradina Soto**, National Cancer Institute Doctoral Trainee, University of Southern California

Colleen Stevens, Branch Chief, California Department of Public Health, Tobacco Control Program

****Josaphine Stevenson**, Food Procurement Project Lead, California Department of Public Health, Office of Health Equity

****Pamela Stoddard**, Senior Epidemiologist, Santa Clara County Public Health Department

***Elisa Tong**, Associate Professor, University of California Davis, Department of Internal Medicine

****Gustavo Torrez**, Network for LGBT Health Equity

Kimi Watkins-Tartt, Director, Community Health Services Division, Alameda County Public Health Department

****Statice Wilmore**, Program Coordinator II/ PIO, City of Pasadena Public Health Department Tobacco Control Program

Appendix C:

Health Equity Summit Agenda

California Tobacco Control Program HEALTH EQUITY SUMMIT
Advancing Health Equity in Tobacco Control

June 25-26, 2013 | Sacramento, California
Hyatt Regency Sacramento | Capitol View Room, 15th floor

AGENDA

SUMMIT OBJECTIVES:

- Examine how to tackle existing norms in California that exacerbate tobacco-related disparities;
- Creatively think about how underlying causes of tobacco use can be addressed through tobacco control-related policy, system, and environmental change approaches;
- Discuss ways to integrate tobacco control efforts with other chronic disease, alcohol and drug use prevention, and behavioral health initiatives in order to maximize health outcomes; and
- Create a vision for California that builds on past successes while incorporating new collaborative thinking.

Day 1: Tuesday, June 25, 2013

7:30 - 8:15 a.m.	**Registration, Breakfast and Meet and Greet**
8:15 – 8:20 a.m.	**Welcome, Purpose and Housekeeping** **Kristi Maryman**, Program Consultant, California Tobacco Control Program, California Department of Public Health
8:20 – 8:50 a.m.	**Agenda Setting and Introductions** **Larry Cohen**, Founder and Executive Director, Prevention Institute Dalila Butler, Program Coordinator, Prevention Institute Shayla Spilker, Program Assistant, Prevention Institute

8:50 - 9:00 a.m. **Framing, Context and Possibilities**
Colleen Stevens, Branch Chief, California Tobacco Control Program, California Department of Public Health

9:00 – 10:00 a.m. **Reducing Tobacco-Related Health Disparities and Advancing Health Equity: Utilizing What We Know Works**

- **David Hopkins**, Medical Officer, Centers for Disease Control and Prevention
- **Linda Rudolph**, Principle Investigator, Health in All Policies, Public Health Institute

Larry Cohen, Founder and Executive Director, Prevention Institute (Panel Facilitator)

9:45 – 10:00 a.m.
Group Discussion

10:00 – 10:15 a.m. **Break**

10:15 – 11:00 a.m. **Exploring the Landscape of California Tobacco Use Inequities Gallery Walk & Discussion**

10:15 – 10:30 a.m.
Gallery Instructions & Reflection Questions Review
Shayla Spilker, Program Assistant, Prevention Institute

10:30 – 10:45 a.m.
Gallery Walk

10:45 – 11:00 a.m.
Facilitated Question & Answer
Dalila Butler, Program Coordinator, Prevention Institute
Jonathan Isler, Chief, Evaluation and Knowledge Management Section, California Tobacco Control Program, California Department of Public Health

11:00 – 12:15 p.m. **Highlighting Successful Strategies: Integrating Health Equity Approaches to Reduce Tobacco Use Disparities**

- **Effective Tobacco Control Policies among Navajo people**
  Patricia Nez-Henderson, Vice President, Black Hills Center for American Indian Health

- **Retail Policy Strategies that Most Impact Disparate Populations**
  Lisa Henriksen, Senior Research Scientist,
  Stanford Prevention Research Center

- **Medi-Cal Incentives to Quit Smoking (MIQS) Project**
  Elisa Tong, Assistant Professor of General Medicine,
  UC Davis Health System

Gustavo Torrez, Program Manager, The Network for LGBT Health Equity (Panel Facilitator)

12:00 – 12:15 p.m.
Group Discussion

12:15 – 1:15 p.m.	**Lunch** Special Lunch Presentation: **Reverend Jesse Brown**, Save Lives: Ban Menthol Cigarettes Campaign
1:15 – 1:30 p.m.	**Instructions for Small Group Breakouts**
1:30 – 3:00 p.m.	**Small Group Work Part 1**: Policy/System Change Brainstorming, Analysis, and Strategy Recommendations
3:00 – 3:15 p.m.	**Break**
3:15 – 3:45 p.m.	**Small Group Work Report Backs to Larger Group**
3:45 – 4:50 p.m.	**Large Group Priority Setting and Consensus Building**
4:50 – 5:00 p.m.	**Recap of the Day and Preview of Day 2**
5:00 p.m.	**Adjourn**

Day 2: Wednesday, June 26, 2013

7:30-8:30 a.m.	**Breakfast**
8:30 – 8:45 a.m.	**Day 1 Re-cap and Review Activities for Day 2**
8:45 – 9:45 a.m.	**Small Group Work Part 2: Identifying Operational Strategies**

9:45 - 10:00 a.m.	**Break**
10:00 – 10:45 a.m.	**Larger Group: Common Themes and Recommendations**
10:45-11:15 a.m.	**Key Considerations Moving Forward** Maintaining the Momentum: Highlights from the Health Equity Summit **Larry Cohen**, Founder and Executive Director, Prevention Institute
11:15-11:45 a.m.	**Summit Participant Reflections**
11:45 to 12:00 p.m.	**California Tobacco Control Program Next Steps** **April Roeseler**, Chief, Community and Statewide Interventions Section, California Tobacco Control Program, California Department of Public Health
12:00 -1:00 p.m.	**Lunch and Adjourn**

Appendix D:

Description of Data Charts & Link

For an online copy of the data charts used during the Summit, please visit:
http://www.cdph.ca.gov/programs/tobacco/Pages/CTCPFactSheets.aspx

View - Health Equity Summit - Data Charts (June 2013)
Smoking behavior data for several race/ethnic, gender, income categories.

Appendix E:

Description of Day 1 and Definition of Small Workgroup Breakouts

TOPIC	DEFINITION
Place: What's sold & how it's promoted (I. RETAIL)	Availability and promotion of safe, healthy, affordable, culturally appropriate products and services
Place: What's sold & how it's promoted (II. NON-RETAIL ENVIRONMENTS)	Availability and promotion of safe, healthy, affordable, culturally appropriate products and services
Place: Look, feel & safety; Getting around/transportation	Surroundings that are well-maintained, appealing, perceived to be safe and culturally inviting for all residents. Availability of safe, reliable, accessible and affordable ways for people to move around.
Place: Housing	High-quality, safe and affordable housing that is accessible for residents with mixed income levels.
Place: Parks & open space	Availability and access to safe, clean parks, green space and open areas that appeal to interests and activities across the generations.
Place: Air, water & soil	Safe and non-toxic water, soil, indoor and outdoor air.
People & Equitable Opportunity: Social networks & trust; Participation & willingness to act for the common good; Norms and culture; Education; Living wages & local wealth	Trusting relationships among community members. Individual capacity, desire, and ability to participate to improve the community. Broadly accepted behaviors that promote health, wellness and safety. Access to high quality living wage employment and quality education.
Healthcare: Preventative services; Access; Treatment quality, disease management, in-patient services, & alternative medicine; Cultural competence; Emergency response	High-quality, accessible, affordable medical care, including good medical, mental health and dental services.

Appendix F:

Description of Collaboration Multiplier Tool

Collaboration Multiplier: Enhancing the Effectiveness of Multi-Field Collaboration

Collaboration Multiplier is an interactive tool for strengthening collaborative efforts across diverse fields. A multi-field approach has proven vital for tackling today's complex social challenges. Whether the goal is promoting health equity, strengthening local economies, reducing greenhouse gas emissions, or enhancing community safety, improving our well-being requires community-wide changes that include strengthening government policies and the practices of key organizations. Multi-field collaboration expands available resources, strategies, and capabilities to achieve outcomes that could not be accomplished by one field alone.

Collaboration Multiplier provides a systematic approach to laying the groundwork for multi-field collaboration. The tool guides organizations through a collaborative discussion to identify activities that accomplish a common goal, delineate each partner's perspective and potential contributions, and leverage expertise and resources. **Collaboration Multiplier** is based on the understanding that different groups and sectors have different views of an issue and different reasons for engaging in a joint effort. For example, a collaborative formed to increase access to healthy food in underserved neighborhoods can more effectively engage partners by recognizing that each has their own goals. A grocery store operator might expand fresh food offerings to enhance sales and profits, a health department would support the effort to improve health, and the Mayor might see enhanced food retail as fundamental for a flourishing community. **Collaboration Multiplier** helps surface these perspectives and forge strategies that advance their objectives simultaneously.

Collaboration Multiplier can be used in different stages of collaboration. It can be used by a newly formed or established partnership that wants to strengthen its collective effort, or it can be used by an individual or small set of organizations that recognize the value of a diverse partnership and want to think strategically about whom to invite to the table.

The Collaboration Multiplier Process

Collaboration Multiplier occurs in two phases: 1) Information Gathering and 2) Collaboration Multiplier Analysis

In the first phase, the key sectors and fields that can contribute to a solution are identified. Then key information from the perspective of each field (or prospective field) is collected according to a common set of categories. Specific categories vary based on the particular collaboration, but typical examples include:

- **IMPORTANCE**: Why is this issue important?
- **ORGANIZATIONAL GOALS**: What are the goals related to this issue?

- **AUDIENCE**: Who is the primary audience/constituency?
- **EXPERTISE**: What unique expertise does this field bring to the collaborative?
- **ASSETS/STRENGTHS**: What resources (skills, staff, training capacity, funding) can be brought to the table?
- **KEY STRATEGIES**: What key strategies/activities are currently implemented relevant to this issue?
- **DESIRED OUTCOMES**: What specific results/outcomes are desired as a result of this collaboration? What does success look like?
- **DATA**: What data is collected, and how?
- **PARTNERSHIP**: Which partners/participants can be brought to the table to enhance outcomes?
- **ORGANIZATIONAL BENEFIT**: What is the benefit of participating in this collaborative?

Partner	Importance	Organizational Goals	Expertise	Assets & Strengths	Key Strategies	Desired Outcomes	Partnership	Organizational Benefit

Compiling this information can provide a "big picture" snapshot for partners and lays the groundwork for a collaborative discussion.

In the next phase, the collaborative engages in a "collaboration multiplier analysis" to discuss the implications based on the information collected. Some key areas of discussion can include:

- What partner strengths can the collaborative utilize? How do you leverage each partner's expertise?
- What results and outcomes can be achieved together?
- What strategies/activities can two or three partners work together on?

Collaboration Multiplier serves as a starting point for appreciating what different fields can bring to the table and for building effective interdisciplinary efforts through partnership. After completing the two-phase process, partners can begin developing a comprehensive strategy to achieve their shared vision. To support strategic efforts, **Collaboration Multiplier** is designed to complement and inform Prevention Institute's **Spectrum of Prevention**, a tool for developing multifaceted activities for effective prevention, and **The Eight Steps to Effective Coalition Building**, a step-by-step guide for coalition development and sustainability. Effective collaboration can be a powerful force for mobilizing individuals to action, bringing health and safety issues to prominence, forging joint solutions, and developing effective policies. By working through **Collaboration Multiplier**, partners will see the fruits of their efforts grow exponentially.

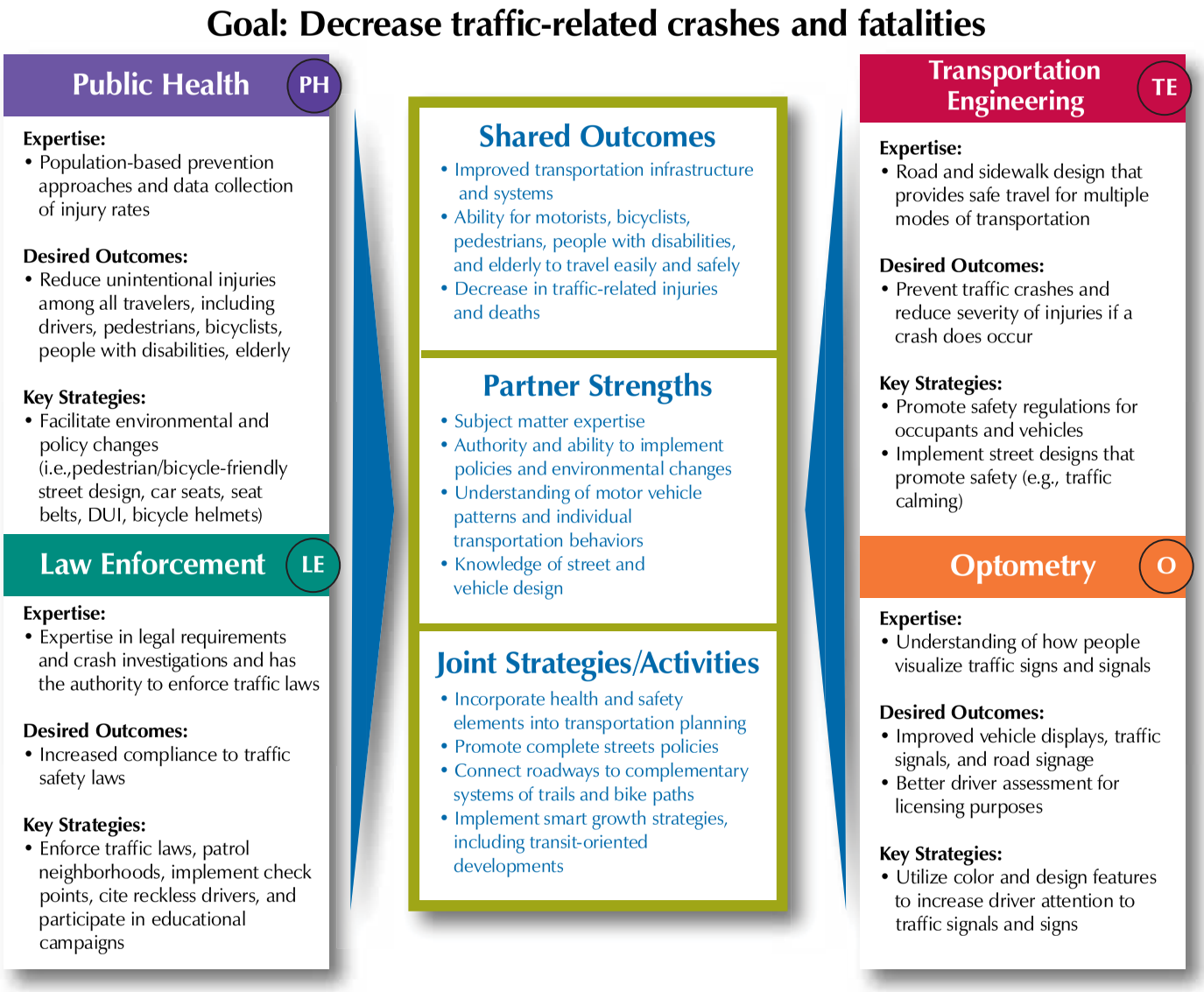
For more information, visit Prevention Institute's website at www.preventioninstitute.org.

Collaboration Multiplier Example: Traffic Safety Coalition
(This is a sample; expected levels of detail would be greater)

Phase I: Information Gathering

	Expertise	Desired Outcomes	Strategies
Public Health	Population-based prevention approaches and data collection of injury rates	Reduce unintentional injuries among all travelers, including drivers, pedestrians, bicyclists, disabled, elderly	Facilitate environmental and policy changes (i.e., pedestrian/bicycle-friendly street design, car seats, seat belts, driving under the **influence, bicycle** helmets)
Law Enforcement	Expertise in legal requirements and crash investigations and has the authority **to enforce traffic laws**	Increase compliance **to traffic safety laws**	**Enforce traffic laws**, patrol neighborhoods, implement check points, cite reckless drives, and participate in educational campaigns
Transportation Engineering	Road and sidewalk design that provides safe travel for multiple modes of transportation	**Prevent traffic crashes** and reduce severity of injuries if a crash occurs	Promote safety regulations for occupants and vehicles Implement street designs that promote safety
Optometry	Understanding of how **people visualize traffic** signs and signals	Improve vehicle **displays, traffic** signals, and road signage Better driver assessment for licensing purposes	Utilize color and design features to increase driver **attention to traffic** signals and signs

Phase II: Collaboration Multiplier Analysis



Appendix G:

Description of Prevention Institute

Prevention Institute was founded in 1997 to serve as a focal point for primary prevention practice—promoting policies, organizational practices, and collaborative efforts that improve health and quality of life. As a national non-profit organization, the Institute is committed to preventing illness and injury, to fostering health and social equity, and to building momentum for community prevention as an integral component of a quality health system. Prevention Institute synthesizes research and practice; develops prevention tools and frameworks; helps design and guide interdisciplinary partnerships; and conducts training and strategic consultation with government, foundations, and community-based organizations nationwide and internationally.

Taking a comprehensive, integrated approach to solving complex health and social issues, the Institute advances prevention efforts that address multiple problems concurrently. The Institute catalyzes quality prevention strategies that are well designed, reflect and respond to diverse community needs and assets, and achieve far-reaching outcomes. By translating previous accomplishments to new prevention measures, the Institute helps practitioners and decision-makers to achieve outcomes that are enduring and sustainable. Prevention Institute maintains a core focus on promoting health equity and primary emphases include preventing violence, traffic injuries, and chronic disease.

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Health Equity
Social Justice
Reducing Disparities
Influencing Policy
Differences in Health
Evidence-Based
Healthy Communities
Priority Populations
Leadership
Culture
Achieving Equity
Primary Prevention
Changing Organizational Practices
Upstream Interventions
Positive Norms
Environments Shape Behaviors
Reduce Smoking Prevalence
Choice
Value
Care
Resources
Empowerment